Department of Veterans Affairs

Pain as the 5Th Vital Sign Toolkit

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Revised Edition

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PREFACE

This toolkit has been prepared as a resource manual for use by Veterans Health Administration (VHA) managers and staff in implementing the VHA National Pain Management Strategy. More specifically, the toolkit has been designed to promote Pain as the 5th Vital Sign and to offer guidelines for the completion of comprehensive pain assessments. These are the initial steps in promoting and improving pain management for veterans receiving care within the VHA system.

This information is intended for reference only and is provided for use in the development of local pain assessment procedures.

The Take 5 logo was graciously provided for the VA by Accel Healthcare Communications, New York.

CONTENTS

Preface 1

Contents 2

Acknowledgements 4

- Toolkit Task Force 4
- Content Reviewers 4

Section 1: Introduction 5

- Veterans Health Administration (VHA) National Pain Management Strategy 5
- Why Pain as the 5th Vital Sign 5
- Overview of the Toolkit 6

Section 2: An Overview of the VHA National Pain Management Strategy 7

- Implementing the Pain as the 5th Vital Sign Mandate 7

Section 3: Barriers to Pain Screening and Assessment 11

- Healthcare Professionals 11
- Patients 11
- Healthcare System 12

Section 4: The Pain Screening Process 13

- Keys to Successful Pain Screening 13
- The Numeric Rating Scale (NRS) 13
- Tips for Successful Use of the Numeric Rating Scale 14
- Suggested Script and Answers to Questions Patient's Frequently Ask 15
- Alternatives to the Numeric Rating Scale 16
- When to Screen for Pain 17
- Documenting Pain Scores 17
- Interpreting Pain Scores 18

Section 5: Comprehensive Pain Assessment 20

Assessing the "Person with Pain" 20

Overview of the Comprehensive Pain Assessment Process 20

Components of the Comprehensive Pain Assessment Interview 21

Documenting the Comprehensive Pain Assessment 21

Footnotes in Sections 1 through 5 22

Section 6: Educational and Resource Information 23

VHA National Pain Management Policy 23

VHA National Pain Management Strategy Coordinating Committee 25

VISN Pain Management Points of Contact (POCs) 29

Education Service Representatives (ESRs) 32

Electronic Documentation of Pain Scores 33

Examples of Paper Documentation Forms 39

Examples of Local Facility Pain Assessment Tools and Templates 41

Pain Assessment Resources 43

Joint Commission on Accreditation of Healthcare Organizations (JCAHO) Standards Related to the Assessment and Treatment of Pain 51

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Toolkit Task Force

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Content Reviewers

Numerous individuals both within and beyond the VHA healthcare system contributed time and talent as reviewers of the original draft of this Pain as the 5th Vital Sign Toolkit. We gratefully acknowledge their contributions, specifically recognizing the members of the VHA National Pain Management Strategy Coordinating Committee, members of the VISN 1 Pain Management Subcommittee, and staff of the Comprehensive Pain Management Center at the VA Connecticut Healthcare System.

SECTION 1: INTRODUCTION

Veterans Health Administration (VHA) National Pain Management Strategy

VHA has initiated a comprehensive national strategy for pain management. The overall goal of the new VHA National Pain Management Strategy is to prevent pain and suffering in persons receiving care in the veterans healthcare system. The specific objectives of this strategy are to:

- ?? Provide a system-wide VHA standard of care for pain management that will reduce suffering from preventable pain.
- ?? Assure that pain assessment is performed in a consistent manner.
- ?? Assure that pain treatment is prompt and appropriate.
- ?? Include patients and families as active participants in pain management.
- ?? Provide for continual monitoring and improvement in outcomes of pain treatment.
- ?? Provide for an interdisciplinary, multi-modal approach to pain management.
- ?? Assure that clinicians practicing in the VHA healthcare system are adequately prepared to assess and manage pain effectively.

Why Pain as the 5th Vital Sign

The phrase "pain as the 5th vital sign" was initially promoted by the American Pain Society to elevate awareness of pain treatment among healthcare professionals.

> Vital Signs are taken seriously. If pain were assessed with the same zeal as other vital signs are, it would have a much better chance of being treated properly. We need to train doctors and nurses to treat pain as a vital sign. Quality care means that pain is measured and treated.
>
> James Campbell, MD
> Presidential Address, American Pain Society
> November 11, 1996

VHA recognizes the importance of making pain "visible" in an organization. Screening, assessing, and documenting pain routinely is an important first step in assuring that unrelieved pain is identified and treated promptly.

It is important to emphasize that Pain as the 5th Vital Sign is a screening mechanism for identifying unrelieved pain. Screening for pain can be administered quickly for most patients on a routine basis. As with any other vital sign, a positive pain score should trigger further assessment of the pain, prompt intervention, and follow-up evaluation of the pain and the effectiveness of treatment.

Overview of the Toolkit

This Pain as the 5th Vital Sign Toolkit has been prepared as a resource toolkit for use by healthcare professionals. It is organized into the following sections:

Section 1: Introduction. This section presents the objectives of the VHA National Pain Management Strategy and a synopsis of the major sections of this toolkit.

Section 2: An Overview of the VHA National Pain Management Strategy. This section highlights the key components of the strategy and provides recommendations for implementation at individual VHA facilities (or in individual healthcare facilities if it is being used by non-VHA systems).

Section 3: Barriers to Pain Screening and Assessment. This section reviews many of the common barriers to reliable pain screening and assessment, including barriers attributable to healthcare professionals, patients, and the healthcare system. Appreciation of the factors is critical to the development of an effective program for pain management.

Section 4: The Pain Screening Process. This section includes information about the Numeric Rating Scale (NRS) for pain screening, a description of the tool, tips for using it reliably; guidelines for frequency of screening across diverse clinical settings; and suggestions for using the tool within the context of patient/family education on pain and pain management. This section also contains information on methods for documenting pain scores in the patient record.

Section 5: Conducting a Comprehensive Pain Assessment. This section emphasizes the role of pain screening as an initial step in the comprehensive assessment of pain. The section discusses pain as a complex, perceptual phenomenon and provides a rationale for more comprehensive assessment. Key components and commonly employed methods of pain assessment are also described, followed by a description of common barriers to reliable pain assessment.

Section 6: Educational and Resource Information. This section provides information to assist individuals and facilities in the successful implementation of the Pain as the 5th Vital Sign initiative.

SECTION 2: AN OVERVIEW OF THE VHA NATIONAL PAIN MANAGEMENT STRATEGY

Pain as the 5th Vital Sign is just one element of the VHA National Pain Management Strategy. It is the first step toward assuring that all persons cared for in the VHA healthcare system can reliably count on prompt and appropriate treatment of pain.

The VHA Pain as the 5th Vital Sign initiative establishes the routine screening and assessment of pain and the documentation of a plan for pain reduction as national policy throughout the VHA healthcare system.

The essential components of this initiative are:

- ?? Routine pain screening for the presence and intensity of pain for all patients using a 0-to-10 Numeric Rating Scale (NRS).
- ?? Documentation of present pain intensity (i.e., "pain score") for all patients as part of the vital sign record.
- ?? Completion of a comprehensive pain assessment, as clinically indicated, for patients reporting a significant level of pain.
- ?? Documentation of the comprehensive pain assessment, the plan for improved pain management, and a timeframe for reassessment.

Implementing the Pain as the 5th Vital Sign Mandate

Implementing Pain as the 5th Vital Sign will require every VHA medical facility to do the following:

- ?? Develop a comprehensive implementation plan for the facility.
- ?? Plan and implement methods for pain screening and assessment.
- ?? Provide for routine documentation of pain scores and assessment.
- ?? Provide education for healthcare providers, e.g., physicians, nurses. Education should include instruction on how to use the NRS, documentation procedures, and interpretation of the results; how to conduct a comprehensive pain assessment and documentation requirements; and how to develop a plan for effective pain management and how to document it.
- ?? Educate patients and families about pain screening, assessment, patient rights and responsibilities related to pain management, and available pain management/treatment options.

Develop an implementation plan for your facility.

?? Designate a person or team who will be responsible for implementing Pain as the 5th Vital Sign.

?? Establish an action plan with timelines and assigned responsibilities. Implementing Pain as the 5th Vital Sign in all sites of care should be approached as the first step in a comprehensive plan to continuously improve pain management. It will be necessary to develop further guidelines and procedures for more comprehensive pain assessment and follow-up for patients for whom pain is identified as a problem.

?? Share the plan with your VISN Pain Management Point of Contact (POC). See pages 29-31 in Section 6 of this toolkit for a list of VISN POCs.

Plan methods for pain screening and assessment at all sites of care.

?? Review the VHA National Pain Management Policy and the JCAHO Standards Related to the Assessment and Treatment of Pain, both in Section 6 of this toolkit.

?? Identify procedures and guidelines for pain screening and assessment that are currently being used in your facility and/or VISN. Keep in mind that the NRS is simply an initial screening tool and is only the first step toward achieving consistent pain assessment for all patients. You may already have more comprehensive pain assessment procedures in place in some sites of care.

?? Identify local pain management experts to assist in developing and reviewing policies and procedures.

?? Review pain screening and assessment resources (see Section 6).

?? Establish policies and procedures for your facility.

?? Incorporate pain screening and assessment procedures into appropriate facility manuals, handbooks, publications, and other facility reference materials as is needed.

?? Develop an implementation plan for documenting pain scores in the medical record (see Section 4).

?? Develop an implementation plan for documentation of comprehensive pain assessments and care plans.

Educate healthcare providers on pain assessment.

?? The Employee Education System (EES) can provide valuable assistance in developing educational materials and coordinating educational programs. Include your VISN Education Service Representative (ESR) as well as your facility and VISN education committee in planning for educational activities. See page 32 in Section 6 of this toolkit for an ESR contact list and the Web address for updates.

?? Each facility has an Education Point of Contact Person (POC) who can be identified by reviewing the list in Outlook under "VHA Education POCs."

?? Identify the target audience for Pain as the 5th Vital Sign, e.g., physicians, nurses, nurses aides, medical technicians, pharmacists, therapists, chaplains, social workers. Consider a broad audience for initial, basic education. Remember that one objective of this initiative is to raise awareness of the importance of pain assessment and pain management throughout the organization. All members of the healthcare team should be able to understand and use the NRS. Professional staff who will have responsibility for conducting comprehensive pain assessments and for the development of plans for pain management/treatment will necessarily require additional specialized training.

?? Identify educational resources (see Section 6). A wide array of published materials is available, as well as information on the Internet that can be readily adapted for use in staff education.

?? Identify local pain management experts to assist in the development of employee education programs and materials.

?? Develop an educational plan with a timetable and assigned responsibilities. Keep in mind that this is an ongoing project. Consider starting with the basics and building more detailed and comprehensive educational programs over time. Ask: What does staff need to know? Who needs to know? When, where, and how should training be provided?

?? Incorporate pain assessment into the initial orientation and ongoing education of all appropriate staff.

?? Share your education plan with your VISN Pain Management Point of Contact (POC) and your VISN Education Service Representative (ESR). See lists in Section 6 of this toolkit.

Educate patients and families.

?? Identify the contact person for patient education in your facility and/or your VISN patient education committee. Enlist their assistance in coordinating your patient education activities. A listing of local "Patient Education Contacts" is available in Outlook.

?? Identify patient and family education materials on pain assessment and pain management that are already in use in your facility and/or VISN.

?? Identify local experts to assist with the development of patient and family education materials.

?? Identify educational resources (see Section 6). There is an abundance of published materials, as well as information on the Internet designed for patient and family education related to pain assessment and treatment.

?? Review the JCAHO Standards Related to the Assessment and Treatment of Pain provided in Section 6 of this toolkit, paying particular attention to the chapters on "Rights and Ethics" and "Education."

?? Develop a plan for educating patients and families on pain assessment and management. Again, keep in mind that this is an ongoing effort. Establish priorities and a realistic

timeline based on an assessment of needs and resources available. Consider starting with a simple instruction tool for use of the NRS for rating pain intensity.

?? Share your plan for patient and family education with your VISN Pain Management Point of Contact (POC), listed in Section 6 of this toolkit.

Use the Numeric Rating Scale (NRS) to teach patients and families.

?? Define the word "pain." For example, you might describe "pain" as a physical discomfort that may have various characteristics such as aching, pulling, tightness, burning, or pricking, and you might explain that pain may be mild to severe.

?? To verify that the patient understands how the word "pain" (or other word preferred by the patient) is used, ask the patient to give examples of pain he or she has experienced. If the patient is already in pain, use the present situation as the example.

?? Emphasize to the patient and family that the patient's self-report of pain is the single most reliable indicator of how much pain the patient is experiencing. Explain that the patient must volunteer information. Although caregivers will ask about pain regularly, they do not know when the patient has pain unless the patient reports it. This information helps staff establish pain relief satisfactory to the patient. Emphasize also that the patient's report about his/her pain level is always what is recorded in the patient's record.

?? Show the patient and family the NRS and explain that its primary purpose is to provide quick, consistent communication between the patient and caregivers, including nurse and physician. Explain that 0 represents no pain, while 10 represents the worst possible pain. If the patient does not understand, select another pain intensity scale.

?? If the patient reports more than one site or painful condition, discuss the importance of providing a single, global measure of pain intensity. The patient should be encouraged to take into account a primary site of pain (e.g., surgical wound) but also to consider all other relevant sites of pain, as well.

?? Ask the patient to practice using the NRS by rating his/her present painful experiences or those that he/she remembers.

?? Ask the patient what pain rating would be acceptable or satisfactory to him/her. This helps set a realistic, initial goal. Zero pain is not always possible. Once the initial goal is achieved, the possibility of better pain relief can then be considered. Emphasize to the patient that satisfactory pain relief is a level of pain that is not distressing, and one that enables the patient to sleep, eat, and perform other required physical activities.

SECTION 3: BARRIERS TO PAIN SCREENING AND ASSESSMENT

Before presenting the key parameters of the pain screening and assessment process, it is important to consider the numerous obstacles to this process.

The patient's subjective pain experience may be difficult to communicate because the patient and provider have different languages, experiences, expectations, and frames of reference. Prior to assessment, it is important that the provider be aware of and sensitive to these types of barriers. A range of additional barriers attributable to healthcare professionals, patients, and the healthcare system have also been articulated and deserve special attention in promoting reliable pain assessment and optimal pain management.

Traditional patterns of professional practice may be among the most difficult barriers to overcome. Healthcare providers and institutions must address these barriers in their practice settings to assure that all patients receive quality pain care.[1]

Healthcare Professionals

How we think about pain influences the way we go about evaluating a person who reports the presence of pain. Assessment of pain is also influenced by learned behavioral responses from a given culture or subculture. It is important that all practitioners be aware of how their own biases may influence pain assessment. The following may affect practitioners' responses to patients' reported pain:

- Attitudes - Fear of patient addiction. Concern that attention to pain may encourage additional complaints of pain and medication seeking.
- Skills - Inadequate knowledge and experience related to pain assessment and management.
- Knowledge - Concern about the side effects of analgesics.
- Practice behavior - Failure to routinely assess and document.

Patients

Patient barriers may make pain assessment more difficult, prevent successful application of a useful treatment, or block the recovery process. Some examples of patient barriers are:

- Language or cultural barrier
- Chemical dependency
- Physical, emotional, or sexual abuse
- Litigation
- Chaotic psychosocial lifestyle

- Medical illness
- Reluctance to report pain or use the word “pain”
  - Fear that having pain may indicate a more serious disease than if there were no pain
  - Concern about not being a “good” patient
  - Fear of diagnostic tests, procedures, or medications
- Reluctance to take pain medications
  - Fear of addiction
  - Worries about side effects

Healthcare System

Barriers within the healthcare system may be due to:

- A low priority given to pain care
- Inadequate reimbursement for costly care given to patients
- Restrictive regulation of controlled substances
- Lack of access to pain specialists

SECTION 4: THE PAIN SCREENING PROCESS

Pain as the 5th Vital Sign is a strategy for promoting increased attention to unrecognized and under-treated pain among patients receiving care in the VHA healthcare system. The strategy calls for a routine screening, where patients are asked whether they are experiencing pain and are then asked to rate the intensity of their pain using the 0-to-10 Numeric Rating Scale (NRS) on which 0 equals no pain while 10 represents the worst possible pain. The number reported by each patient is the pain score and should be documented in the medical record. The presence of pain at any level serves a cue to the provider to conduct additional assessment and to initiate interventions designed to promote pain relief, as clinically indicated.

Documentation of pain scores in a systematic and consistent manner is an important mechanism for promoting identification of unrelieved pain at the individual patient care level. It is also the first step toward implementation of a single standard of care and a system-wide approach to improving pain management throughout the VHA healthcare system. Availability of pain scores will provide important information for the VHA about the presence and intensity of pain problems among veterans receiving care in its healthcare system. Finally, the availability of pain scores will provide an important index for monitoring improvement in pain management throughout the system.

Keys to Successful Pain Screening

Successful pain screening relies on practitioners' consistent commitment to several core concepts:

- ?? The patient's self-report of pain is the single most reliable indicator of pain.
- ?? Observations of behavior and vital signs should not be used instead of self-report unless the patient is unable to communicate.
- ?? Pain can occur when there is no physiological cause, and it is just as real to the patient.

The Numeric Rating Scale (NRS)

There is no pain thermometer. Measurements of pain must rely on patients' self-reports or the inferences we can make based on their behaviors. Screening for pain intensity is an important aspect of patient care.

For several reasons, the VHA has chosen the NRS as the tool for pain screening:

1. A large body of research supports the reliability and validity of the NRS as a single index of pain intensity or severity, and it compares favorably to other commonly employed strategies.

2. Studies suggest that the NRS is valid for use in the assessment of acute, cancer, or chronic nonmalignant pain and in varied clinical settings.

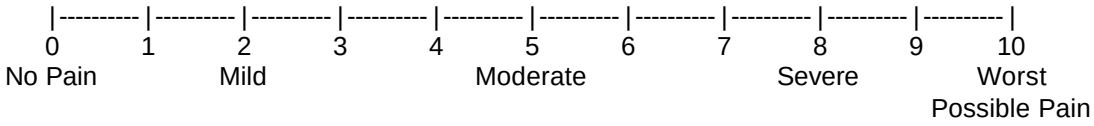
3. The NRS is simple for practitioners to describe and easy for most patients to understand and use. There is evidence of a high degree of compliance with the task.

4. The NRS can generally be administered orally and does not require instrumentation.[2]

Visual alternatives to screening (e.g., oral, numeric, pictorial) are also reliable and can similarly be used to derive a 0-to-10 score. These various alternative methods are important in accommodating the special requirements of particular patients (e.g., hearing impaired and dysphasic patients) or settings of care (e.g., postoperative settings where oral responses are limited). Some alternative methods are briefly discussed below, and some examples are provided in Section 6 of this toolkit.

The NRS is scored by numeric integers, 0 through 10. The NRS may be used either verbally or visually. Pain intensity levels are measured upon initial visit, following treatment, and periodically, as guidelines dictate.

Numeric Rating Scale (NRS)



When using the NRS for pain, the provider would ask, "On a scale of zero to ten, where zero means no pain and ten equals the worst possible pain, what is your current pain level?"

An individual often experiences pain in more than one site in his/her body. In these situations, patients may be confused about what site to emphasize in reporting their experience of pain using the NRS. Practitioners should encourage the patient to provide a single, global estimate of pain intensity.

Tips for Successful Use of the Numeric Rating Scale

?? Allow sufficient time to elicit the patient's self-reported pain rating.

?? Provide an environment that is quiet and free of distractions.

?? Have appropriate aids for hearing and vision available, e.g., charts with enlarged words, numerical scales, anatomical drawings.

?? Speak slowly, clearly, and as loudly as needed.

?? Involve family members and/or caregivers.

?? Use enlarged copies (8½" x 11") of the NRS.

?? Teach the patient how to use the pain rating scale.

?? Explain the use of the scale each time it is administered.

?? Use the same pain rating scale each time pain is evaluated.

?? Provide ample time for the patient to respond to questions.

?? If the patient cannot respond verbally, try having him or her point to enlarged words, numerical scales, or anatomical drawings.

?? Have the patient provide a single, global estimate of pain intensity.

Suggested Script and Answers to Questions Patient's Frequently Ask

1. (Name of patient) are you having any pain today?

Yes *No*

2. Please rate your pain on a zero to ten scale with zero being no pain and ten as the worst pain you can imagine. (Show the patient the pain scale)

"My pain is a 6."

3. You have reported a pain score of 6 (> = 4). This is a significant level of pain; I want you to discuss this with your doctor or nurse practitioner today.

Frequently Asked Questions

Q. "Why are you asking me about my pain?"

A. We take pain very seriously and consider it a vital sign. You can expect to be asked about pain each time you see your primary doctor or nurse practitioner and when someone takes your other vital signs such as your temperature or blood pressure.

Q. "Why do you keep asking me about my pain if you never do anything about it?"

A. If you are not getting your pain relieved, you need to make it clear to your doctor or nurse practitioner that you are continuing to have pain.

Q. "Why do I need to use this 0-10 scale?"

A. There is no pain thermometer. We must rely on your report of pain. You are the only one who can let us know when you are having pain. When you receive treatment for pain, using the pain scale allows us to evaluate whether the pain treatment is effective.

Q. "I don't really have pain, but I do have aching; is that pain?"

A. People experience physical discomfort that they may label as something other than pain. This may include aching, pulling, tightness, burning, pricking or even fatigue. I want you to rate this aching experience on the pain scale. This will help us in making an assessment.

Q. "What is an acceptable pain score?"

A. Every person is an individual. It is best if people determine what pain rating is acceptable for them. Zero pain is not always possible. Acceptable pain relief is a pain level that is not distressing, and one that allows you to sleep, eat and perform your regular daily activities.

"I don't like this pain Scale."

We know some individuals have difficulty using this simple zero to ten scale. In using this scale we are only trying to get an overall measure of your pain intensity or severity. Your response to other questions will help us understand the true nature of your pain, such as the quality of your pain and the impact of your pain on your life. Perhaps you can think of word descriptors, such as mild, moderate and severe. Remember that 10 equals the worst pain imaginable. Now can you rate your pain severity between zero and ten?

Q. *My Pain is a 15.*

A. You must be in a lot of pain to select 15 on a 10 point scale. We like to use the scale to measure progress in the pain medications and treatment you receive. Let's look at the scale again and think of the number 10 as the worst pain imaginable and 0 as a time in your life when you had not pain at all. Now, try the scale again.

Alternatives to the Numeric Rating Scale

Patients who are confused or unable to express themselves also need to be screened for pain. The NRS may not be useful for these patients, and alternative methods of pain screening may be necessary. Those who know the patient well may be able to provide information about pain history, typical behaviors when the patient has pain, and activities that may cause pain. References related to assessing pain in confused and nonverbal patients have been included in the resource list. For patients who are cognitive and able to provide verbal responses, these alternative scales are not to be considered as a routine substitute for the numeric rating scale (NRS).

The practitioner should realize that the most accurate data for assessing pain is obtained in the following order:

1. Patient's report of pain
2. Reports of patient's pain by patient's family or friends
3. Patient's behaviors
4. Physiological parameters

When to Screen for Pain

The establishment of guidelines for the frequency of pain screening is an important aspect of the implementation of the Pain as the 5th Vital Sign initiative. The intent of the strategy is to promote routine screening for pain in order to overcome the numerous barriers to effective pain screening, assessment, and management that are articulated in Section 3 of this toolkit.

Healthcare systems and/or facilities may want to establish specific policies and procedures that mandate the frequency of routine screening for the presence and intensity of pain. Such policies may specify different frequencies of screening and assessment for different clinical care settings and/or patient populations.

In inpatient and residential settings, screening for the presence and intensity of pain should occur upon admission and then routinely according to established protocol based on the type of setting and as clinically indicated for the individual patient. For example, in the postoperative care setting, pain screenings may occur very frequently for an acute period immediately postoperatively and then decrease in frequency as pain diminishes. In the palliative care or end-of-life setting, frequent screening of pain is likely to be a critical component of optimal care. Alternatively, in the inpatient mental health setting and long-term care settings, initial screening and assessment may reveal a chronic, stable pain problem that requires infrequent reassessment. Nevertheless, regular screening that encourages identification of new onset pain or acute exacerbations of pain is also necessary.

In the outpatient setting, patients should be screened for pain on each patient visit or encounter, as is clinically indicated for the setting and the individual patient. For example, in the primary care setting, as well as in most medical and surgical clinical settings, screening should take place at every visit regardless of the original reason for the visit. In outpatient and community mental health settings where frequent encounters with providers typically occur, a plan for less frequent, but regular screenings may be appropriate.

Documenting Pain Scores

Standardized documentation is an important element of the Pain as the 5th Vital Sign initiative. Documentation of pain scores is essential in planning and evaluating effective pain management. Standardized documentation of pain scores will also make it possible to collect data across the VHA healthcare system for purposes of research, evaluation of pain management strategies, and quality measurement. All VA healthcare facilities must implement one of the following documentation methods:

- ?? Electronic
- ?? Paper

Electronic documentation of the numeric pain score

VHA Information Services has developed an enhancement for the current software version of Vitals/Measurements, Version 4.0 to support the documentation of Pain as the 5th Vital Sign. All facilities that are using the VHA Information Systems and Technology Architecture (**VISTA)** computerized patient record should enter pain scores electronically, along with the other vital signs. The pain score can be recorded from one of the following applications:

- ?? Vitals
- ?? Nursing
- ?? CPRS GUI Cover Sheet
- ?? CPRS GUI Encounter Form

Instructions for recording a pain score in the computerized patient record can be found on page 33 in Section 6 of this toolkit, together with a sample report that contains the pain score and other vital signs. If you have questions about the software or the instructions, please contact your local Information Resources Management (IRM) service office or your local Clinical Application Coordinator for further assistance.

Paper documentation of the numeric pain score

If your facility is not yet using the computerized patient record, then you must implement a paper documentation system that mirrors the electronic system. Pain scores must be routinely charted on the patient's vital sign record. You may adapt the vital sign record or vital sign flow sheet that you are currently using. If you are not currently using a vital sign record or flow sheet at your site, you may implement a new form. When scoring, use 99 when the patient is unable to report a pain score. Only use 0 when the patient reports no pain or a score of 0.

Examples of paper documentation of vital signs are provided on pages 39 and 40 in Section 6 of this toolkit.

Interpreting Pain Scores

It is critical to remember that the patient's report of pain on the NRS is a subjective index of that individual's experience or perception of pain, and even more accurately, a method for the patient to communicate with his/her provider(s) about that experience. It should not be viewed as an absolute or objective index that is directly related to existing physical pathology or "cause" of pain. Even a relatively low pain score may represent an intolerable level of pain for some individuals. On the other hand, a relatively high pain score for some individuals may represent the best level of pain management possible given existing treatment alternatives.

It is generally agreed that scores between 1 and 4 are indicative of a mild level of pain intensity. Scores of 5 and 6 are consistent with moderate levels of pain. Scores of 7 or higher are reflective of severe pain.

In developing procedures and guidelines for pain assessment, it is important to remember that the first goal of Pain as the 5th Vital Sign to determine if pain is present. The second goal is to determine the intensity of the pain. The NRS is a measure of pain intensity. The third goal of pain assessment is to determine the significance of the pain. Achievement of the third goal will usually require more comprehensive pain assessment. It is reasonable to expect that a pain score of 4 or higher would trigger a comprehensive pain assessment and prompt intervention. It is likely that in the near future VHA will establish a standard threshold for comprehensive pain assessment based on national experience.

SECTION 5: COMPREHENSIVE PAIN ASSESSMENT

Assessing the "Person with Pain"

According to the International Association for the Study of Pain (IASP)[3],

> Pain is an unpleasant sensory and emotional experience associated with actual and potential tissue damage or described in terms of such damage.

Pain is a complex perceptual experience involving all domains of an individual's life, not just physical pathology. It is a subjective phenomenon that is uniquely experienced by each person. Understanding and appropriately treating patients experiencing pain requires an accurate evaluation, not only of the organic pathology that may be causing the pain, but also a myriad of behavioral and psychosocial factors, each of which contributes to the subjective report.[4] Thus, it is imperative that practitioners assess the "person with pain," not just the pain alone.[5]

Overview of the Comprehensive Pain Assessment Process

Reliable and comprehensive assessment of pain is the cornerstone of effective pain management. Routine screening for the presence of pain is the first step in an ongoing process of comprehensive pain assessment, prescriptive planning for optimal pain management, delivery of interventions targeting pain, and reassessment and refinement of the pain management plan. Effective pain management hinges on the availability of a thorough and reliable assessment of pain.

Pain assessment is an interactive and collaborative process involving the patient and family, nurse, physician, and other providers, as appropriate to the clinical setting. It is the basis for selecting an appropriate intervention. Healthcare providers must accept and respect patients' reports of pain and proceed with appropriate assessment and treatment.

Comprehensive assessment of pain is informed by a biopsychosocial model that emphasizes the important interaction of biological, psychological, and social/cultural contributors to the experience of pain. Assessment also attends to the potential negative impacts of pain on such areas as sleep, mood, activity, appetite, energy, and functioning, including social functioning and relationships.

The primary mode of pain assessment is the clinical interview. The interview is commonly supported by direct observation of the patient's behavioral manifestations of pain (for example, rubbing affected body parts, bracing, guarding, facial grimacing, sighing) and other signs of physiological stress and arousal.

Other common components of the comprehensive pain assessment process include:

- ?? A thorough and focused physical examination
- ?? Additional medical diagnostic procedures

?? The use of standardized paper-and-pencil questionnaires and inventories

There is a wide array of pain assessment tools and resources that may be useful in developing pain assessment procedures and guidelines for your facility.[6] The list of pain assessment resources provided in Section 6 of this toolkit includes both publications and Web sites that provide excellent examples of pain assessment tools and guidelines.

In most settings, pain assessment is interdisciplinary in nature, routinely involving physicians, nurses. When evaluating complex, chronic pain conditions, additional healthcare professionals (e.g., rehabilitation medicine specialists, pharmacists, psychologists) often participate in the comprehensive pain assessment and treatment planning process. Their perspectives are all respected as critical to the development of a reliable and comprehensive understanding of the patient's pain and associated problems. It is through this interdisciplinary process that a comprehensive and multi-modal plan for effective pain management can be developed and implemented.

Components of the Comprehensive Pain Assessment Interview

In assessing pain, important questions to ask include, but are not limited to, the following:

?? Are you having pain now?

?? Where is your pain?

?? What does it feel like?

?? Is the pain always there? Does the pain come and go?

?? How long have you had the pain?

?? What makes the pain better?

?? What makes the pain worse?

?? Are you experiencing any other symptoms?

?? How does the pain affect your activity, sleep, appetite, mood, social functioning and relationships, energy, and overall quality of life?

?? On a scale of 0 to 10, what number represents your (functional) tolerable level of pain?

Documenting the Comprehensive Pain Assessment

At the present time, the VHA has not distributed standardized protocols or electronic templates for documenting the results of comprehensive pain assessments. However, many facilities may have established clinical pathways for pain or other pain documentation packets that can be used as local templates for documentation. Examples of local pain assessment templates are provided in Section 6 of this toolkit.

Documentation of the comprehensive pain assessment should include the following key components:

- ?? Complete description of the pain experience, including information about its prevalence (e.g., constant, intermittent, episodic, recurring), location(s), character, duration, factors that influence pain, effects on functioning, sleep, appetite, and mood, etc.
- ?? Summary of impressions and diagnosis(es)
- ?? Detailed plan for pain management/treatment
- ?? Specific timeframe for reassessment

Sites that utilize VISTA software, particularly Computerized Patient Record System (CPRS), Clinical Reminders, Education Topics and Health Factors, Text Integration Utilities (TIU) Progress Notes, and Health Summary reports, could develop aids to support their local pain management efforts.

Footnotes in Sections 1 through 5

[1]Gordon, D., Dahl, J., & Stevenson, K. (Eds.) (1996). *Building an institutional commitment to pain management: The Wisconsin resource manual for improvement.* Wisconsin Pain Initiative. Madison, WI: University of Wisconsin-Madison.

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[4]Loesser, J.D., & Melzack, R. (1999). Pain: An overview. *Lancet, 353,* 1607-1609.

[5]Turk, D.C., & Okifuji, A. (1999). Assessment of patient's reports of pain: An integrated perspective. *Lancet, 353,* 1784-1788.

[6]Turk, D.C., & Melzack, R. (1992). *Handbook of pain assessment.* New York: Guilford Press.

SECTION 6: EDUCATIONAL AND RESOURCE INFORMATION

This section provides information to assist individuals and facilities in the successful implementation of the VHA National Pain Management Strategy, including the Pain as the 5th Vital Sign initiative.

VHA National Pain Management Policy

1. **Purpose**: The purpose of the VHA National Pain Management Strategy is to develop a system-wide approach to pain management that will reduce suffering by veterans experiencing acute and chronic pain associated with a wide range of illnesses, including terminal illness.

2. **Background**: Pain is a significant healthcare problem in the United States; a substantial portion of the population is afflicted with pain each year. Recent surveys and studies have determined that 20% to 30% of the population annually suffers from acute pain and/or chronic pain syndromes. Further, the incidence and severity of pain increase with increasing age, resulting in a disproportionately large amount of chronic pain occurring in individuals over 60 years of age. Control of cancer pain remains a substantial, unresolved problem with 75% of advanced cancer patients experiencing "moderate" to "very severe" pain.

   The knowledge and techniques to control most pain are known, but they are often not applied effectively. Proactive, aggressive management of both acute and chronic pain is universally recognized as an essential component of healthcare; however, substantial evidence indicates that neither acute nor chronic pain is managed adequately within most U.S. healthcare systems. It is essential that VHA develop a systematic approach to pain management that assures that pain is recognized and treated promptly and effectively.

3. **Objectives:** The overall objective of this policy is to prevent pain and suffering in persons using the veterans healthcare system. The specific objectives of this policy are to:

   - ?? Provide a system-wide VHA standard of care for pain management that will reduce suffering from preventable pain.
   - ?? Assure that pain assessment is performed in a consistent manner.
   - ?? Assure that pain treatment is prompt and appropriate.
   - ?? Include patients and families as active participants in pain management.
   - ?? Provide for continual monitoring and improvement in outcomes of pain treatment.
   - ?? Provide for an interdisciplinary, multi-modal approach to pain management.
   - ?? Assure that clinicians practicing in the VHA healthcare system are adequately prepared to assess and manage pain effectively.

4. **Key Elements of the Strategy:**

?? **Pain Assessment and Treatment**. Procedures for early recognition of pain and prompt effective treatment shall be implemented by all VA medical treatment facilities. VHA will implement Pain as the 5th Vital Sign in all clinical settings to assure consistent assessment of pain. Pain management protocols will also be established and implemented in all clinical settings.

The complexity of chronic pain management is often beyond the expertise of a single practitioner, especially for patients whose pain problems are complicated by homelessness, posttraumatic stress disorder, combat injuries, and substance abuse. Primary care providers should have ready access to resources such as pain specialists and multidisciplinary pain clinics and centers to effectively evaluate and manage these complex patients. Pain management is an integral part of palliative and end-of-life care. The expertise of hospice and palliative care clinicians should be available to all patients with serious, life-limiting illnesses. Patient and family education about pain and its management should be included in the treatment plan, and patients should be encouraged to be active participants in pain management.

?? **Evaluation of Outcomes and Quality of Pain Management**. All VHA medical facilities will implement processes for measuring outcomes and quality of pain management with the goal of continuous improvement. Electronic data monitoring of pain assessment and effectiveness of pain management interventions will be implemented. Patient satisfaction will be monitored on an ongoing basis.

?? **Clinician Competence and Expertise in Pain Management**. All VHA medical facilities will assure that appropriate clinical staff (e.g., physicians, nurses, and therapists) have appropriate orientation and employee education related to pain assessment and pain management. VHA standards for pain management will be communicated to all medical students, allied health professional students, residents, and interns providing patient care in VHA medical facilities. VHA education programs will be developed that include principles of pain assessment and management.

?? **Research**. VHA will expand its basic and applied research on management of acute and chronic pain, emphasizing conditions that are most prevalent among veterans. Research funded by the Health Services Research and Development Service (HSR&D) will encourage a systematic approach to identifying research priorities and providing scientific evidence on which to base pain management protocols throughout VHA and for evaluating and monitoring the quality of care.

?? **Coordination of National VHA National Pain Management Strategy**. The consistent and effective management of pain for all veterans cared for by VHA requires a coordinated national approach. An interdisciplinary committee will be established to oversee the development and implementation of the VHA National Pain Management Strategy. The Committee will be charged with the following responsibilities:

1. Coordinate the system-wide implementation of Pain as the 5th Vital Sign.

2. Coordinate the development and dissemination of state-of-the-art treatment protocols for pain management.

3. Identify VHA pain management expertise and resources, and facilitate a national referral system to assure that veterans in every network have access to pain management services.

4. Coordinate a national employee education initiative to assure that VHA clinicians have the expertise to provide high-quality pain assessment and treatment.

5. Identify research opportunities and priorities in pain management, and facilitate collaborative research efforts.

6. Integrate VHA pain management standards into the curricula and clinical learning experiences of medical students, allied health professional students, interns, and resident trainees.

7. Establish target goals, mechanisms for accountability and a timeline for implementing the comprehensive, integrated VHA National Pain Management Strategy.

8. Establish a communication plan for both the internal and external communication of the VHA National Pain Management Strategy.

References

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New guidelines on managing chronic pain in older persons. *JAMA, 280(4)*.

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Quality improvement guidelines for the treatment of acute pain and cancer pain, *JAMA, Vol.274(23)*, 1874-1880.

VHA pain management survey. Headquarters Anesthesia Service, July 1997.

VHA National Pain Management Strategy Coordinating Committee

A multidisciplinary national committee was appointed by the Under Secretary for Health to coordinate the VHA National Pain Management Strategy. This committee includes representatives from acute care, geriatrics and extended care, nursing, pharmacy, psychology, health services research and development, employee education, and information services. The role of the committee is to coordinate the implementation of the VHA National Pain Management Strategy in a way that effectively uses VHA resources and expertise to achieve the national goals. This is a long-term initiative and it is expected that a variety of subcommittees and workgroups will be identified to focus on specific aspects of the national strategy.

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VISN Pain Management Points of Contact (POCs)

Every VISN has identified a point of contact (POC) for the VHA National Pain Management Strategy (see Section 6). The function of the POC is to facilitate communication and the flow of information between the Coordinating Committee and field staff in each VISN.

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Education Service Representatives (ESRs)

The ESR assigned to your VISN can provide you with details on the earning activities, products, and services available to VA employees through the Employee Education System. You may send e-mail to an individual or get the latest information from the Web site http://vaww.ees.lrn.va.gov/.

VISN	Location	ESR Name	Phone	Pager
1	Boston	Steve King	202-745-8433	888-264-7865
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3	Bronx	Barbara Woodrick	516-754-7914 x 2910	888-264-7828
4	Pittsburgh	Diana Higginbotham	304-626-7715	cell: 202-262-9783
5	Baltimore	Gerry Kelly	410-642-2411 x 5453	888-264-7612
6	Durham	Melissa Scherwinski	919-680-6841 x 243	877-328-4934
7	Atlanta	Jennifer Harris	404-321-6111 x 3566	888-431-4858
8	Bay Pines	Debbie Peeples	205-731-1812 x 314	888-431-4858
9	Nashville	Michael Barrett	615-867-5834	888-691-8253
10	Cincinnati	Mark Kriynovich	614-257-5459	800-722-3908
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17	Dallas	Sharon Sutton	210-617-5300 x 4708	888-691-8252
18	Phoenix	Saundra Overstake	602-277-5551 x 3402	800-722-3659
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21	San Francisco	Rob Wilson	707-561-8376	888-688-3753
22	Long Beach	Ken Flint	562-494-5505 x 3997	888-264-7708
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*****Pager will not work when person is physically at home site (call first).

Last updated on 6/1/00
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Electronic Documentation of Pain Scores

Entering the Pain Score in the Vitals/Measurement Menu (also accessible from the Nursing package)

```
   1      Vitals/Measurement Data Entry ...
   2      Vitals/Measurements Results Reporting ...
   3      Edit a Vital/Measurement Entered in Error
   4      Vitals/Measurements Site Files Menu ...

Select Vitals/Measurement Option: 1  Vitals/Measurement Data Entry

ENTER DATE (TIME Required) VITALS WERE TAKEN: 11/19/99@15:00  (NOV 19,
1999@15:00)

   1      TPR Pain
   2      TPR B/P Pain
   3      TPR B/P Ht. Wt. and Pain
   4      TPR B/P Wt. and Pain
   5      Temp, Detailed PR and B/P
   6      Detailed B/P and Associated Pulse
   7      Pulse
   8      Weight
   9      Circumference/Girth
   10     Pulse Oximetry
   11     CVP (Central Venous Pressure)
   12     User Configurable Combination
   13     Change Date/Time Taken
   14     Pain

Select Vitals/Measurement Data Entry Option: 1  TPR Pain

Vitals by (A)ll patients on a unit, (S)elected Rooms on unit, or
(P)atient? p
Select PATIENT NAME: squirrEL, GREY           10-25-71     123994567
YES     EMPLOYEE
 Enrollment Priority: GROUP 1    Category: IN PROCESS    End Date:

Select Hospital Location: 13A PSYCH//

Temp-Pulse-Resp-Pain: 98.7-67-15-0

  Temp.: 98.7 F  (37.1 C) ORAL
  Pulse: 67 RADIAL
  Resp.: 15 SPONTANEOUS
  Pain: 0 No pain

Is this correct? YES//
```

If the answer is **Yes**, the pain score is stored. If the answer is **No**, a prompt gives the user the opportunity to re-enter a correct pain score. If the user enters **Yes**, and the stored pain score is incorrect, the Edit a Vital/Measurement Entered in Error option must be used to mark the record in error.

Vitals Reports in the Vitals/Measurement Menu

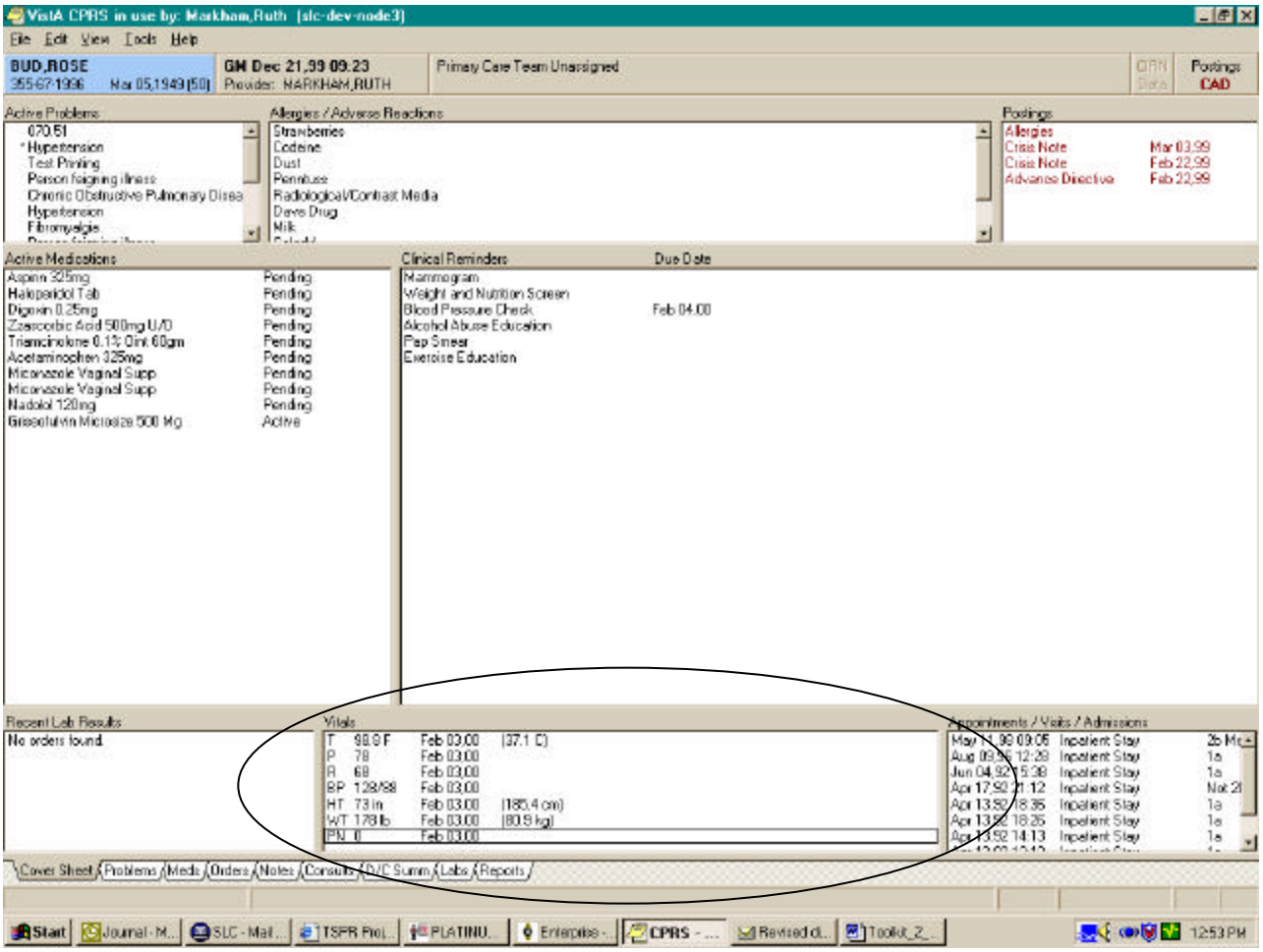
```
Vitals/Measurements Results Reporting Menu

   1      Latest Vitals Display for a Patient
   2      Latest Vitals by Location
   3      Cumulative Vitals Report
   4      Print Vitals Entered in Error for a Patient


DEC 2,1999 (15:38)      Latest Vitals Report                    Page 1
------------------------------------------------------------------


            SQUIRREL,GREY       123-99-4567

Temp.:      (11/29/99@13:50) 98.4 F  (36.9 C)
Pulse:      (11/29/99@13:50) 65
Resp.:      (11/29/99@13:50) 55*
B/P:        (11/29/99@13:50) 121/83
Ht.:        (11/22/99@12:55) 4 ft 3 in (129.54 cm)(ACTUAL)
Wt.:        (11/29/99@13:50) 193 lb  (87.73 kg)
BMI:                         52*
Pain:       (11/29/99@13:50) 3


DEC 02, 1999 (15:41)    Cumulative Vitals/Measurements Report      Page 1
------------------------------------------------------------------
11/19/99
15:00
    T:   98.7 F (37.1 C) (ORAL)
    P:   67 (RADIAL)
    R:   15 (SPONTANEOUS)
    Pain: No pain
11/22/99
12:55
    T:   102.4 F (39.1 C)* (ORAL)
    P:   62 (RADIAL)
    R:   52* (SPONTANEOUS)
    B/P: 111/85
    Ht:  51.00 in (129.54 cm) (ACTUAL)
    Wt:  185.00 lb (84.09 kg) (ACTUAL)
    Body Mass Index: 50*
    Pain: 5
13:00
    Pain: 10 - Worst imaginable pain
11/29/99
13:50
    T:   98.4 F (36.9 C)
    P:   65
    R:   55*
    B/P: 121/83
    Wt:  193.00 lb (87.73 kg)
    Pain: 3
11/30/99   11:40    Pain: Unable to respond
```

Viewing Vitals from CPRS List Manager

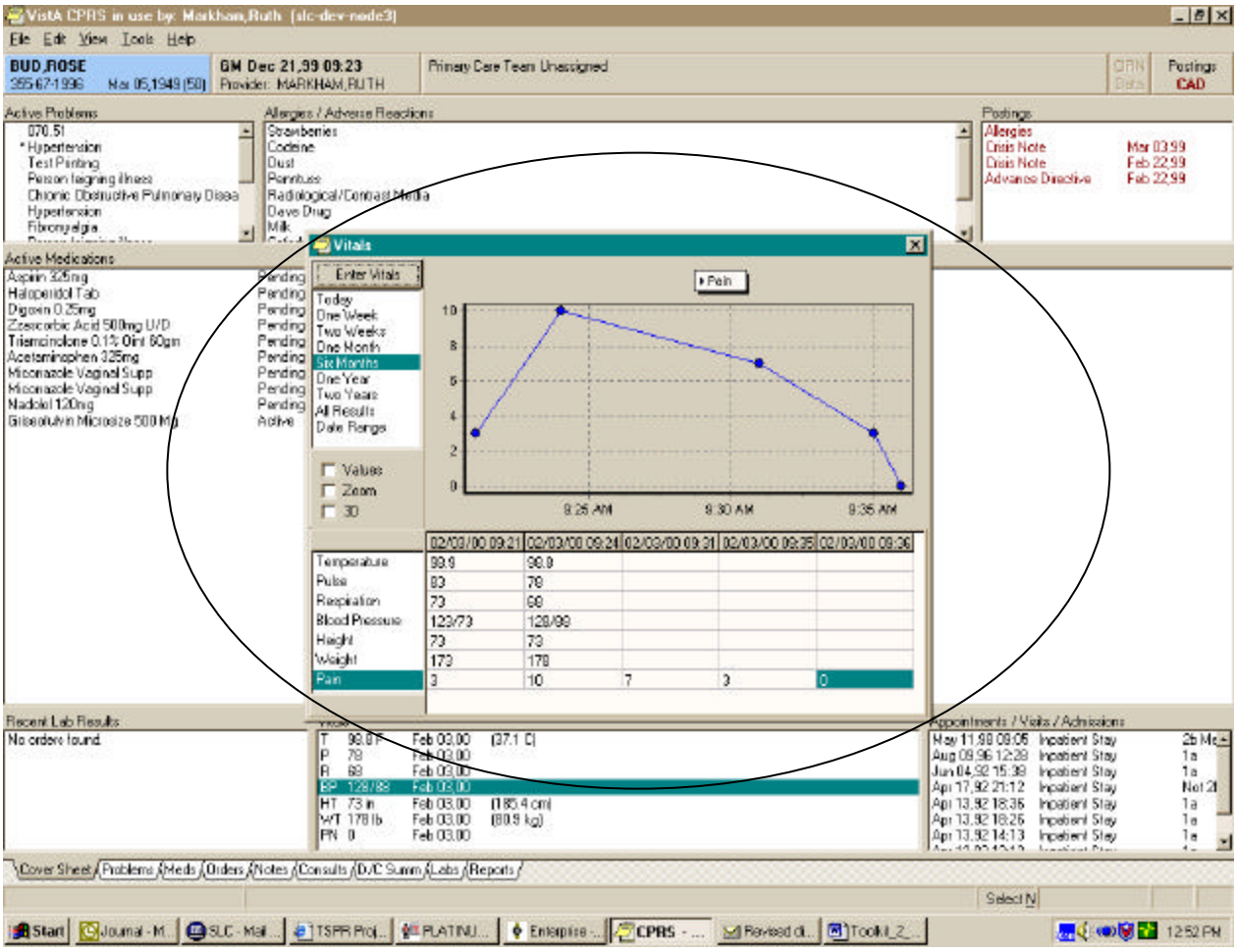
```
CPRS Clinician Menu
Cover Sheet                    Nov 24, 1999 13:18:19          Page:    1 of  2
SQUIRREL,GREY          123-99-4567            13A        10/25/71(28)
Attend: WELBY,R    PrimCare:   UNKNOWN     PCTeam:

<CA>
     Item                                        Entered
_
     Allergies/Adverse Reactions                |
1    MILK (sneezing, dry mouth)                 | 05/24/99
2    rat dander (itching,watering eyes,         | 05/24/99
     hives, anxiety)                            |
3    Poptarts (nausea,vomiting, dizziness,      | 07/02/99
     dry mouth, rash)                           |
4    CHOCOLATE DOUGHNUTS (nausea,vomiting)      | 08/20/99
                                                |
     Recent Vitals                              |
     Temp:  102.4 F (39.1 C)                    | 11/22/99 12:55
     Pulse: 62                                  | 11/22/99 12:55
     Resp:  52                                  | 11/22/99 12:55
     B/P:   111/85                              | 11/22/99 12:55
     Ht:    51 in (129.5 cm)                    | 11/22/99 12:55
     Wt:    185 lb (83.3 kg)                    | 11/22/99 12:55
     Pain:          10                          | 11/22/99 13:00

+         Enter the numbers of the items you wish to act on.
>>>
NW  Enter New Allergy/ADR CV  (Change View ...)     SP  Select New Patient
AD  Add New Orders        CC  Chart Contents ...    Q   Close Patient Chart

Select: Next Screen//
Select Item(s): Next Screen//
```

Viewing Vitals from CPRS GUI

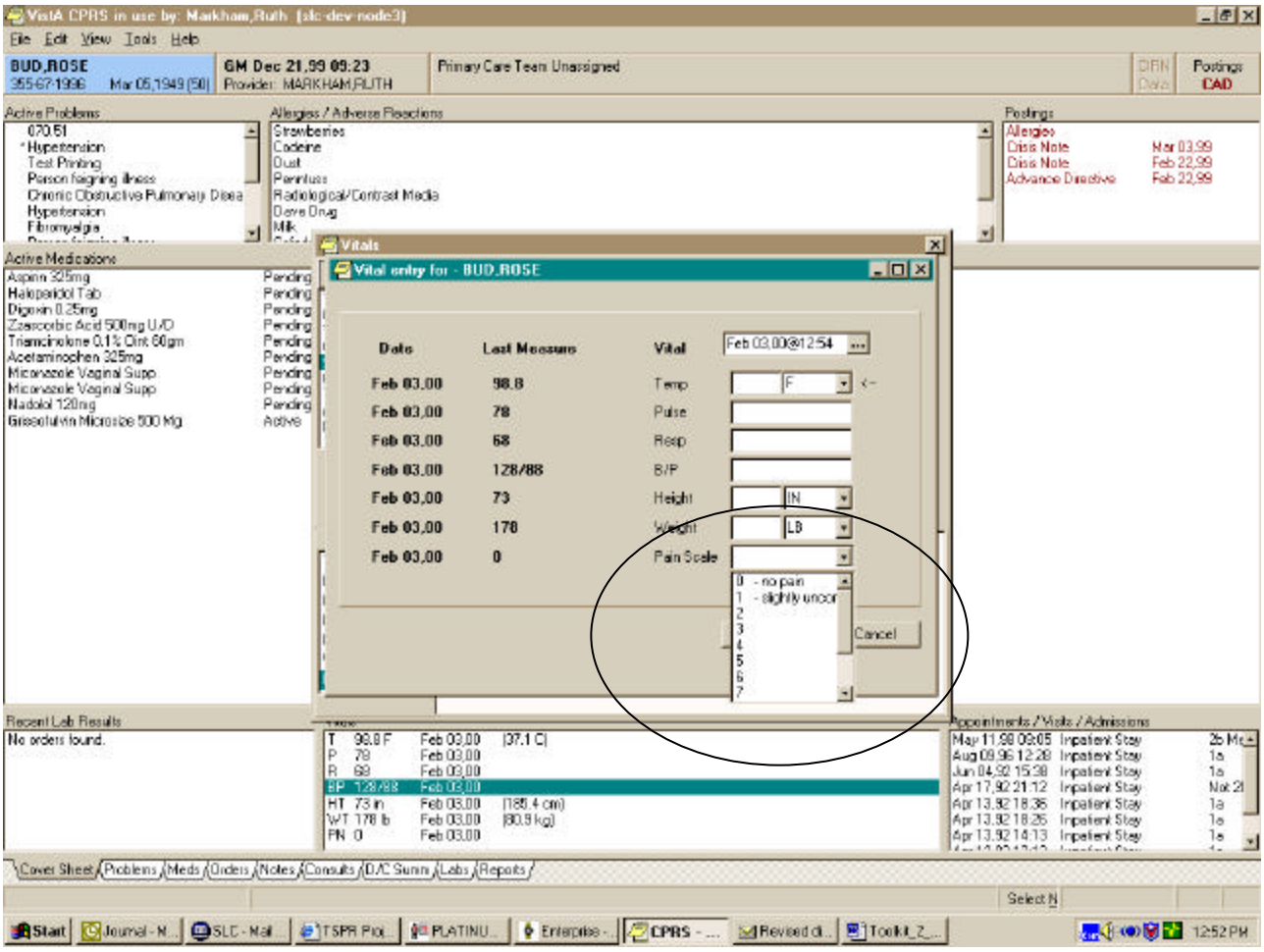
`Vitals displayed from the CPRS GUI Cover Sheet:`



Vitals detail display from the CPRS GUI Cover Sheet:



Vitals data entry from the CPRS GUI Cover Sheet:



Examples of Paper Documentation Forms

Vital Flow Sheet

Date/Time	02-04-99 13:13	02-04-99 13:22	02-05-99 07:00	02-05-99 10:00	02-07-99 07:00	02-07-99 08:00	02-07-99 09:00	02-07-99 10:49	02-07-99 14:00	02-07-99 15:00
Pulse Temp/F/C 150 104/40.0										
140 103/39.4										
130 102/38.9										
120 101/38.3										
110 100/37.8										
100 99/37.2 98.6										
90 98/36.7										
80 97/36.1										
70 96/35.6										
60 95/35.0										
50 94										
Temperature		*98.6T*		*100.2T*	*101.2T*		*100.2T*		*99.8T*	
Pulse	*70 Rad*	*68 Rt Rad Dop Si*			*94 Rad*		*100 Rad*	*80 Rad*	*90 Rad*	
Respiration		*20S Si*			*26S*	*24S*	*26S*	*22S*	*24S*	
Pulse Ox.					*94*	*96*				
L/Min										
%										
Method										
Blood Pressure					*160/92*				*150/84*	
Weight (lb)					*184A*					
(kg)					*83.64*					
Body Mass Index					*25*					
Height (in)					*72A*					
(cm)										
C/G (in)										
(cm)										
CVP (cm H20)			*10.2*							
(mm Hg)			*7.5*							
Intake (24hr)(cc)										
Output (24hr)(cc)										
Pain					*99*	*10*	*3*	*0*	*5*	*4*

T: Temperature P:Pulse C/G: circumference/Girth *-abnormal value **-Anormal value off of graph
PAIN: 99 - Unable to response 0 - No pain 10 - Worst imaginable pain
TEMP - T:Tympanic PULSE - Dop:Doppler Rad: Radial Rt: Right ST: Sitting RESP - S: Spontaneous Si:Sitting HT - A:Acutal WT -A: Actual

SKYWAIKER, LUKE 555-11-2222
MAY 20, I966 (32) MALE
Unit: MICU
Division: SUPPORT ISC
FEB 4,1999 - FEB 11, 1999011:15
Room: MICU-2 Page I

MEDICAL RECORD
VITAL FLOW SHBET
VAF 10.7987 VICE SF 511

Example of Paper Documentation - Vital Flow Sheet

MONTH-YR	DAY												
19	HOUR AM PM												
TEMP.C	TEMP.F	* *	* *	* *	* *	* *	* *	* *	* *	* *	* *	* *	* *
40.0	104.0	* *	* *	* *	* *	* *	* *	* *	* *	* *	* *	* *	* *
		* *	* *	* *	* *	* *	* *	* *	* *	* *	* *	* *	* *
39.4	103.0	* *	* *	* *	* *	* *	* *	* *	* *	* *	* *	* *	* *
		* *	* *	* *	* *	* *	* *	* *	* *	* *	* *	* *	* *
		* *	* *	* *	* *	* *	* *	* *	* *	* *	* *	* *	* *
38.3	102.0	* *	* *	* *	* *	* *	* *	* *	* *	* *	* *	* *	* *
		* *	* *	* *	* *	* *	* *	* *	* *	* *	* *	* *	* *
		* *	* *	* *	* *	* *	* *	* *	* *	* *	* *	* *	* *
37.8	101.0	* *	* *	* *	* *	* *	* *	* *	* *	* *	* *	* *	* *
		* *	* *	* *	* *	* *	* *	* *	* *	* *	* *	* *	* *
		* *	* *	* *	* *	* *	* *	* *	* *	* *	* *	* *	* *
		* *	* *	* *	* *	* *	* *	* *	* *	* *	* *	* *	* *
37.0	100.0	* *	* *	* *	* *	* *	* *	* *	* *	* *	* *	* *	* *
		* *	* *	* *	* *	* *	* *	* *	* *	* *	* *	* *	* *
		* *	* *	* *	* *	* *	* *	* *	* *	* *	* *	* *	* *
37.0	99.0	* *	* *	* *	* *	* *	* *	* *	* *	* *	* *	* *	* *
	98.6	* *	* *	* *	* *	* *	* *	* *	* *	* *	* *	* *	* *
		* *	* *	* *	* *	* *	* *	* *	* *	* *	* *	* *	* *
		* *	* *	* *	* *	* *	* *	* *	* *	* *	* *	* *	* *
		* *	* *	* *	* *	* *	* *	* *	* *	* *	* *	* *	* *
		* *	* *	* *	* *	* *	* *	* *	* *	* *	* *	* *	* *
		* *	* *	* *	* *	* *	* *	* *	* *	* *	* *	* *	* *
		* *	* *	* *	* *	* *	* *	* *	* *	* *	* *	* *	* *
		* *	* *	* *	* *	* *	* *	* *	* *	* *	* *	* *	* *
		* *	* *	* *	* *	* *	* *	* *	* *	* *	* *	* *	* *
		* *	* *	* *	* *	* *	* *	* *	* *	* *	* *	* *	* *
		* *	* *	* *	* *	* *	* *	* *	* *	* *	* *	* *	* *
Pulse													
Respiration													
	(hour)												
Blood Pressure													
	(hour)												
PAIN INTENSITY 0-10 NO PAIN - WORST PAIN	SATISFACTION WITH RELIEF Y=Yes N= No												
FLUIDS	WEIGHT												
INTAKE	I.V.												
INTAKE	Oral												
OUTPUT	Urine												
BATH/SHOWER													
URINE		SUGAR	ACE TONE	SUGAR	ACE TONE	SUGAR	ACE TONE	SUGAR	ACE TONE	SUGAR	ACE TONE	SUGAR	ACE TONE
	7 AM												
	11AM												
	4 PM												
	9 PM												
STOOL													
OCCULT BLOOD													

HEIGHT	WARD NO
MEDICAL RECORD VITAL FLOW SHEET	
VA Form APR 1995 10-7987	

Examples of Local Facility Pain Assessment Tools and Templates

Source: VA Medical Center, New York, NY - Pain Management Team

Pain Assessment Flow Sheet

PAIN INTENSITY SCALE

0 1 2 3 4 5 6 7 8 9 10

No Pain — Worst Pain

DATE	TIME	**P.I.R.** (Pain Intensity Rating) Before	INTERVENTIONS (Medication, physical or psychosocial)	**P.I.R.** After	% OF RELIEF OBTAINED (0-100%)	RESP. RATE (#/MIN)	*LEVEL OF SEDATION	PLAN AND SIGNATURE

Patient's stated level of acceptable pain intensity (0-10 scale)

Acceptable pain intensity _____ DATE _____ Acceptable pain intensity _____ DATE _____

Acceptable pain intensity _____ DATE _____ Acceptable pain intensity _____ DATE _____

*LEVEL OF SEDATION

S = SLEEP, EASY TO AROUSE

1 = ALERT, EASY TO AROUSE

2 = OCCASIONALLY DROWSY, EASY TO AROUSE

3 = FREQUENTLY DROWSY, DIFFICULT TO AROUSE

4 = SOMNOLENT, DIFFICULT TO AROUSE

PATIENT _____

SSN _____ WARD:_____

Pain Assessment Questionnaire

Source: VA Medical Center, Providence, RI

How would you rate the intensity of your pain?

0	1	2	3	4	5	6	7	8	9	10
No Pain		Mild Pain			Moderate Pain			Severe Pain		

Where is your pain located? _____

What is the nature of your pain? Constant ( ) On and off ( )

Does the pain travel to another part of your body? Where?_____

Are there any particular times of the day when it is worse?_____

Can you describe your pain's quality? Aching ( ) burning ( ) shooting ( ) stabbing ( ), other _____

Does your pain interfere with your daily activities? Check all that are applicable:

sleep ( ) appetite ( ) work ( ) relationships ( )

What makes your pain worse? _____What relieves your pain?_____

List all the medicines are you currently taking for your pain.
_____

Does your medicine(s) diminish pain intensity? Yes ( ) No ( )

Rate the pain before taking your medicine:

0	1	2	3	4	5	6	7	8	9	10
No Pain		Mild Pain			Moderate Pain			Severe Pain		

Rate pain after taking medicine:

0	1	2	3	4	5	6	7	8	9	10
No Pain		Mild Pain			Moderate Pain			Severe Pain		

Are you having any side effects from these medicines? If so what are they?
Constipation ( ) Dizziness ( ) Other ( ) _____

What medicine(s) have you used in the past for your pain and why did you stop taking them?
_____

What level of pain can you accept?

0	1	2	3	4	5	6	7	8	9	10
No Pain		Mild Pain			Moderate Pain			Severe Pain		

Pain Assessment Resources

Professional Organizations

American Pain Society, 4700 West Lake Ave., Glenview, IL 60025-1485, 847-375-4715.

International Association for the Study of Pain, 909 NE 43rd St., Suite 306, Seattle, WA 98105, 206-547-6409.

American Society of Pain Management Nurses, 2755 Bristol St., Suite 201, Costa Mesa, CA 92628, 714-545-1305.

American Academy of Pain Management, 13947 Mono Way #1, Sonora, CA 95370, 209-533-9750.

American Academy of Pain Medicine, 4700 West Lake Ave., Glenview, IL 60025-1485.

American Association for the Study of Headache, 19 Mantua Road, Mt. Royal, NJ 08061.

American Society of Anesthesiologists, 520 N. Northwest Hwy, Park Ridge, IL 60068-2753, 847-825-5586.

American Society of Regional Anesthesia, P.O. Box 11086, Richmond, VA 23230-1086, 804-282-0010

Educational Materials

Videotapes

Williams & Wilkins complete video library of pain. Twelve videotapes with resource manuals. For a free preview, call 800-527-5597. Williams & Wilkins Electronic Media Division, 428 E. Preston St., Baltimore, MD 21202, 800-527-5597, fax: 410-528-4422.

McCaffery on pain: Nursing assessment & management, 1991. Four videotapes, 30 min. each. All four for $595. For a free preview, call 800-527-5597. Williams & Wilkins Electronic Media Division, 428 E. Preston St., Baltimore, MD 21202, 800-527-5597, fax: 410-528-4422.

McCaffery: Contemporary issues on pain management, 1994. Four videotapes, 30 min. each. All four for $595. For a free preview, call 800-527-5597. Williams & Wilkins Electronic Media Division, 428 E. Preston St., Baltimore, MD 21202, 800-527-5597, fax: 410-528-4422.

Hospice medicine: Pain and symptom management, Veterans Health Administration, Geriatrics and Extended Care, Washington, DC. Produced by National Media Development Center, Office of Academic Affairs, November, 1994.

My word against theirs (cancer pain). For free showing of the following videotapes, contact the local company representative; write to Purdue Frederick Co., 100 Connecticut Ave., Norwalk, CT 06856; or call 203-853-0123.

Assessing compliance with the new pain management standard (*complex organizations.)* Joint Commission on Accreditation of Healthcare Organizations (JCAHO). (1999) One Renaissance Blvd., Oakbrook Terrace, IL 60181. For information on other Pain Management videotapes contact Customer Service center at 630-792-5000. Available in each VA library

Free educational materials for patients and families

Oral morphine: Information for patients, families & friends. Drs. Robert Twycross & Sylvia Lack, Roxane Laboratories, Inc., P.O. Box 16532, Columbus, OH 43216.

Home care of the hospice patient (for family caregivers). Purdue Frederick Co., 100 Connecticut Ave., Norwalk, CT 06856, 800-877-0123.

A bill of rights for people with cancer pain. Cancer Care, Inc., 1180 Avenue of the Americas, New York, NY 10036.

No more pain. (1991). For complimentary copy and information on bulk sales, contact Pain Management Center, Fox Chase Cancer Center ,7701 Burholme Ave., Philadelphia, PA 19111.

Questions and answers about pain control: A guide for people with cancer and their families. Contact Cancer Information Service, 800-4-CANCER (free) or American Cancer Society, 800-227-2345.

Agency for Health Care Policy and Research (AHCPR) guidelines

To order any of the free publications listed below, contact the AHCPR Clearinghouse, P.O. Box 8547, Silver Spring, MD 20907, 800-358-9295 or 301-495-453.

Acute pain management in adults: Operative procedures.
Quick Reference Guide for Clinicians No. 1a.
AHCPR Publication No. 92-0019: February 1993

Pain control after surgery, A patient's guide.
Consumer Guideline Number 1
AHCPR Publication No. 92-0021: February 1993

Acute pain management: Operative or medical procedures and trauma.
Clinical Practice Guideline No. 1.
AHCPR Publication No. 92-0032: February 1992

Management of cancer pain: Adults.
Quick Reference Guide Number 9
AHCPR Publication No. 94-0593: March 1994

Managing cancer pain.
Consumer Guide Number 9

AHCPR Publication No. 94-0595: March 1994

Management of cancer pain.
Clinical Guideline Number 9
AHCPR publication No. 94-0592: March 1994

Books

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Other resources

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Sierzant, T., Bauman, P., Belgrade, M., Cook, M., Shephers, M., Regness, E., and Hogan Miller, E. (2000) Pain Management: An interactive CD-ROM for clinical staff development. Aspen Publishers, Inc. 200 Orchard Ridge Dr., Gaithersburg, MD 20878. Customer Service 1-800-234-1660. (Available in all VA libraries.)

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City of Hope MAYDAY Pain Resource Center (MPRC)
Through a grant from the MAYDAY Fund, researchers at the City of Hope National Medical Center have established the MAYDAY Pain Resource Center (MPRC). The center serves as a clearinghouse for information on improving the quality of pain management. A current index of MPRC material is available on request.

City of Hope National Medical Center
The MAYDAY Pain Resource Center
1500 East Durate Road
Durate, CA 91010
phone: 818-359-8111 x 3829
fax: 818-301-8941
Web site: http://mayday.coh.org/_private/home.htm

Web site resources for pain management

Agency for Healthcare Research and Quality (formerly called the Agency for Health Care Policy and Research): http://www.ahrq.gov

American Academy of Pain Medicine: http://www.painmed.org

American Pain Society: http://www.ampainsoc.org

American Council on Headache Education: http://www.achenet.org

American Association for the Study of Headache: http://www.aash.org

American Headache Society: http://ahsnet.org/

American Geriatrics Society: http://www.americangeriatrics.org

American Alliance of Cancer Pain Initiatives: http://www.fhcrc.org/cipr/aacpi

American Pain Foundation: http://www.painfoundation.org

American Society for the Advancement of Palliative Care: http://www.asap-care.com

American Society of Pain Management Nurses: http://www.nursingcenter.com/resources/org_info.cfm?id=47E9D2E8-1A98-11D3-8EB0-0090276F330E

Growth House, Inc. forum on pain management: http://growthhouse.net/~growthhouse

International Association for the Study of Pain: http://www.halcyon.com/iasp

Joint Commission on Accreditation of Healthcare Organizations: http://www.jcaho.org/

Pain, Palliative and Support care: http://www.jr2.ox.ac.uk/cochrane/

Roxane Pain Institute: http://www.roxane.com

Talaria Cancer Pain Management: http://www.talaria.org/

University of Texas, MD Anderson Cancer Center: http://www.mdanderson.org/

University of Wisconsin Pain and Policy Studies Group: http://www.medsch.wisc.edu/painpolicy

VA National Formulary Policy: http://vaww.va.gov/publ/direc/health/direct/197047.doc

Wisconsin Cancer Pain Initiative: http://www.wisc.edu/wcpi/

Worldwide Congress on Pain: http://www.pain.com

Joint Commission on Accreditation of Healthcare Organizations (JCAHO) Standards Related to the Assessment and Treatment of Pain

Background

Current Joint Commission standards address pain management only as this applies to care of the dying patient. The following proposed standards have been developed for several chapters of the *Accreditation Manual* to expand the patient's right to adequate pain assessment and treatment across the continuum of care. These standards and intent statements would require organizations not only to recognize each patient's right to assessment and treatment of pain, but to monitor and manage the pain and to educate staff and patients regarding the importance of effective pain management.

Rights and Ethics Chapter (RI) - Intent for Standard RI.1.2

RI.1.2 Patients are involved in all aspects of their care.

Intent of RI.1.2
Hospitals promote patient and family involvement in all aspects of their care through implementation of policies and procedures that are compatible with the hospital's mission and resources, have diverse input, and guarantee communication across the organization. Patients are involved in at least the following aspects of their care:

- ?? Giving informed consent;
- ?? Making care decisions;
- ?? Resolving dilemmas about care decisions;
- ?? Formulating advance directives;
- ?? Withholding resuscitative services;
- ?? Forgoing or withdrawing life-sustaining treatment:
- ?? Care at the end of life; and
- ?? Effective pain management.

To this end, structures are developed, approved, and maintained through collaboration among the hospital's leaders and others.

Rights and Ethics Chapter (RI) - Standard RI.1.2.8 and Intent

RI.1.2.8 Patients have the right to adequate assessment and treatment of pain.

Intent of RI.1.2.8
Pain is a common part of the patient experience; unrelieved pain has adverse physical and psychological effects. The patient's right to pain management is respected and supported. The organization plans, supports, and coordinates activities and resources to assure the pain of all individuals is recognized and addressed appropriately. This includes:

- ?? Initial assessment and regular re-assessment of pain;
- ?? Education of relevant providers in pain assessment and management;
- ?? Education of patients and families when appropriate, regarding their roles in managing pain as well as the potential limitations and side effects of pain treatments;
- ?? After considering personal, cultural, and/or ethnic beliefs, communicating to patients and families that pain management is an important part of care.

Assessment of Patients Chapter (PE) -- Standard PE.1.4 and Intent

PE.1.4 Pain is assessed in all patients.

Intent of PE.1.4
In the initial assessment, the organization identifies patients with pain. When pain is identified, the patient can be treated within the organization or referred for treatment. The scope of treatment is based on the care setting and services provided. A more comprehensive assessment is performed when warranted by the patient's condition. This assessment and a measure of pain intensity and quality (for example, pain character, frequency, location, duration), appropriate to the patient's age, are recorded in a way that facilitates regular reassessment and follow up according to criteria developed by the organization.

Care of Patients Chapter (TX) - Chapter Overview

The goal of the care of patients function is to provide individualized care in settings responsive to specific patient needs.

Patients deserve care that respects their choices, supports their participation in the care provided, and recognizes their right to experience achievement of their personal health goals. The goals of patient care are met when the following processes are performed well:

- ?? Providing supportive care;
- ?? Treating a disease or condition;
- ?? Treating symptoms that might be associated with a disease, condition, or treatment (e.g., pain, nausea or dyspnea);
- ?? Rehabilitating physical or psychological impairment; and
- ?? Promoting health.

The standards in this chapter address activities involved in these processes, including:

- ?? Planning care;
- ?? Providing care;
- ?? Monitoring and determining outcomes of care;

?? Modifying care; and

?? Coordinating follow-up.

These activities may be carried out by medical, nursing, pharmacy, dietetic, rehabilitation, and other types of providers. Each provider's role and responsibility are determined by their professional skills, competence, and credentials; the care or rehabilitation being provided; hospital policies; and relevant licensure, certification, regulation, privileges, scope of practice, or job description.

***Care of Patients Chapter (TX)* -- Intents for Standard TX.3.3**
TX.3.3 Policies and Procedures support safe medication prescription and ordering.

Intent of TX.3.3
Procedures supporting safe medication prescription or ordering address

?? Distribution and administration of controlled medications, including adequate documentation and record keeping required by law.

?? Proper storage, distribution, and control of investigational medications and those in clinical trial;

?? Situations in which all or some of a patient's medication orders must be permanently or temporarily canceled, and mechanisms for reinstating them;

?? "as needed" (PRN) and scheduled prescriptions or orders and times of dose administration;

?? appropriate use of patient-controlled analgesia (PCA), spinal/epidural, or intravenous administration of medications and other pain management techniques in the care of patients with pain;

?? control of sample drugs;

?? distribution of medications to patients at discharge;

?? procurement, storage, control, and distribution of prepackaged medications obtained from outside sources;

?? procurement, storage, control, distribution and administration of radioactive medications;

?? procurement, storage, control distribution, administration, and monitoring of all blood derivatives and radiographic contrast media.

***Care of Patients Chapter (TX)* - Intent for Standard TX.5.4**
TX.5.4 The patient is monitored during the post procedure period.

Intent of TX.5.4
The patient is monitored continuously during the post-procedure period. The following items are monitored:

- ?? Physiological and mental status;
- ?? Status of or findings related to pathological conditions, such as drainage from incisions;
- ?? Intravenous fluids and drugs administered, including blood and blood components;
- ?? Impairments and functional status;
- ?? Pain intensity and quality (for example, pain character, frequency, location, duration) and responses to treatments; and
- ?? Unusual events or postoperative complications and their management.

Results of monitoring trigger key decisions, such as transfer to an alternative level of care due to a precipitous change in vital signs, or discharge.

***Care of Patients Chapter (TX)* - Introduction to Rehabilitation Care and Services**
Standards, Intents, and Examples for Rehabilitation Care and Services
(Introduction to standards TX.6 thru TX.6.4):

Rehabilitation is designed to achieve an optimal level of functioning, self-care, self-responsibility, independence, and quality of life. Achieving the patient's optimal level of functioning means restoring, improving, or maintaining the patient's assessed level of functioning. Rehabilitation services aim to minimize symptoms, exacerbation of chronic illnesses, impairments, and disabilities.

Qualified professionals provide rehabilitation services consistent with professional standards of practice. All interventions encourage the patient to make choices, to sustain a sense of achievement about treatment progress, and if necessary, to modify participation in the rehabilitation process.

Assessment identifies the patient's physical, cognitive, behavioral, communicative, emotional, and social status and identifies facilitating factors that may influence attainment of rehabilitation goals. Problems may include

- ?? substance use disorders;
- ?? emotional, behavioral, and mental disorders;
- ?? cognitive disorders;
- ?? developmental disabilities;
- ?? vision and hearing impairments and disabilities;
- ?? physical impairments and disabilities; and
- ?? pain interfering with optimal level of function or participation in rehabilitation.

***Education Chapter (PF)* - Standard PF.1.7 and Intent**
PF.1 The patient's learning needs, abilities, preferences, and readiness to learn are assessed.

PF.1.7 Patients are taught that pain management is an essential part of treatment.

Intent of PF.1 Through PF.1.9
Hospitals offer education to patients and families to give them the specific knowledge and skills they need to meet the patient's ongoing health needs. Clearly, such instruction needs to be presented in ways that are understandable to those receiving them.

Openness and flexibility are important elements in patient education, and can make a critical difference in whether the patient follows the instructions. In assessing a patient's needs, abilities, and readiness for education, staff members take into account such variables as:

- ?? The patient's and family's beliefs and values;
- ?? Their literacy, education level, and language;
- ?? Emotional barriers and motivations;
- ?? Physical and cognitive limitations
- ?? The financial implications of care choices … In addition, the hospital uses guidelines in educating patients on the following topics:
- ?? Safe and effective use of medications;
- ?? Safe and effective use of medical equipment;
- ?? Diet and nutrition;
- ?? Understanding pain and the importance of effective pain management;
- ?? Rehabilitation;
- ?? Educational resources in the community; and
- ?? Follow-up care.

The appropriate disciplines are involved in developing these guidelines.

***Continuum of Care and Services Chapter (CC)* - Intent for Standard CC.6.1**
CC.6.1. The discharge process for continuing care based upon the patient's assessed needs at the time of discharge.

Intent of CC.6.1
Discharge planning focuses on meeting the patient's health care needs after discharge. Discharge planning identifies patients' continuing physical, emotional, symptom management (e.g. pain,

nausea, or dyspnea)**,** housekeeping, transportation, social, and other needs, and arranges for services to meet them.

***Improving Organization Performance Chapter (PI)* - Intent for Standards PI.3.1**
PI.3.1 The organization collects data to monitor its performance.

Intent of PI.3.1
Performance monitoring and improvement are data driven. The stability of important processes can provide the organization with information about its performance. Every organization must choose which processes and outcomes (and thus types of data) are important to monitor based on its mission and the scope of care and services provided. The leaders prioritize data collection based on the organizations mission, car and services provided, and populations served (refer to LD.0.00 for priority setting). Data which the organization considers for collection to monitor performance include:

- ?? Performance measures related to accreditation and other requirements;
- ?? Risk management;
- ?? Utilization management;
- ?? Quality control;
- ?? Staff opinions and needs;
- ?? If used, behavior management procedures;
- ?? Outcomes of processes or services;
- ?? Autopsy results, when performed;
- ?? Performance measures from acceptable databases;
- ?? Customer demographics and diagnoses;
- ?? Financial data;
- ?? Infection control surveillance and reporting;
- ?? Research data;
- ?? Performance data identified in various chapters in this Manual; and
- ?? The appropriateness and effectiveness of pain management.